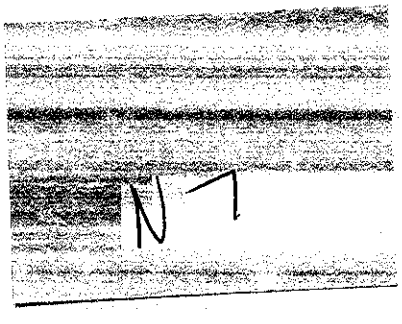
SUPPLEMENTAL AUDIT REPORT OF MONROE COUNTY HEALTH BENEFIT PROGRAM

April 21, 2004

Prepared by:
Internal Audit Department
Clerk of the Circuit Court
Danny L. Kolhage, Clerk
Monroe County, Florida



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April 21, 2004

The Honorable Danny L. Kolhage
Clerk of the Circuit Court

RE: Supplemental Audit Report of Monroe County Health Benefit Program

Dear Mr. Kolhage:

The Clerk's Internal Audit Department has completed the supplemental audit of the Monroe County Health Benefit Program. The purpose of the audit was to determine if additional areas were of concern regarding the efficiency and effectiveness of Acordia National and the Keys Physician Hospital-Alliance (KPHA) in coordinating the plan and to further evaluate County Management's systems employed to monitor the Contractor's performance.

We would like to thank the Division Director of Administrative Services and her staff for their cooperation while conducting the audit. By its nature, this report focuses on exceptions, weaknesses, and problems. This should not be understood to mean there are not also various strengths and accomplishments.

Due the complexity of our Health Benefit Plan and the substantial expenditures involved, the contracts with KPHA, Acordia and providers need to be continuously monitored and improved for clarity.

The audit was conducted with the assistance of Patricia Sutton, Internal Auditor.

The accompanying audit report is provided for your information. Additional copies of the report will be provided upon your request.

Sincerely,

Sandra L. Mathena

Sandra L. Mathena, CPA, CFE, CIA
Director of Internal Audit

Cc: Board of County Commissioners (5)
James Roberts, County Administrator
Richard R. Collins, County Attorney
Sheila Barker, Division Director of Administrative Services
Sandee Carlile, Clerk's Finance Director

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HEALTH BENEFIT PROGRAM

I. OBJECTIVES AND SCOPE

In response to the prior audit of the Health Benefit Program issued May 2003, the Monroe County Clerk of the Circuit Court and the Monroe County Board of Commissioners requested the Internal Audit Department to complete a supplemental audit of the Health Benefit Program.

The audit objectives were to determine if additional areas were of concern regarding the efficiency and effectiveness of Acordia National and the Keys Physician Hospital-Alliance (KPHA) in coordinating the plan and to further evaluate the effectiveness of County Management's systems employed to monitor the Contractor's performance.

II. METHODOLOGY

A. We interviewed the following personnel to obtain information about the Monroe County Health Insurance Plan:

1. County Administrator
2. Director of Administrative Services
3. Group Insurance Administrator
4. The Clerk's Finance Department personnel
5. Assistant Administrator, Lower Keys Medical Center & Director of Operations Keys Physician-Hospital Alliance
6. Vice President of Claims at Acordia National
7. Assistant Vice President and Monroe County's Team Manager at Acordia National
8. Dimension Health Network personnel

B. Internal Audit Department examined the following documents:

1. Monroe County Employer Liaison Committee Agenda's 2003
2. Acordia Refunds & Reversals Audit Report, 2000 to 2003
3. Clerk's Finance Department deposit records
4. KPHA/Dimension provider listings
5. Acordia Referrals by Authorizing Providers, 2000 to 2003
6. Acordia Single Provider Payment Listings
7. Acordia listing of KPHA Providers
8. Acordia Non-PPO Network Savings Report, 2000 to 2003
9. Specific claim detail and invoice detail for large hospital billings
10. Explanation of Benefits (EOB's) from Acordia for specific claims

C. The Internal Audit Department reviewed Single Provider Payment Listing reports for physicians and hospitals.

D. Internal Audit reviewed Referral Analysis By Authorizing Providers reports.

E. Reviewed spreadsheets provided by Acordia calculating claim overpayments.

F. Reviewed Acordia Out of Network reports.

G. Compared Acordia Refund and Reversal reports to Finance Department deposits.

H. Reviewed a sample of claims to determine if appropriate network discounts were applied.

I. Requested Acordia to reprocess claims that were determined to be inaccurate.

III. BACKGROUND INFORMATION

Medical, dental and vision claims of $9,426,645.09 were paid for retirees, employees, and dependents of Monroe County for the fiscal year ending September 2002. This was an increase of 12.1% over claims paid for fiscal year ending September 2001. For the fiscal year September 2003 the paid claims totalled $10,905,253.43. This is an increase of 15.7% over fiscal year 2002 and a 29.7% increase over fiscal year 2001. The County modified several factors of the health benefit program to reduce health care costs for calendar year 2004. The County increased the overall proportion of health care cost paid by the employees and retirees, with anticipation of an approximate 20% decrease in costs.

In the May 2003 report, Audit Report of Monroe County Health Benefit Program, twenty findings were identified. Of the twenty findings, the following overpayments were identified and are not included in the supplemental report:

Acordia Claims Examiner Error	$82,362.44
Employee Portion of Examiner Error	$14,686.26
90th Percentile Medicode Not Updated	$52,877.70
Employee Portion Of Medicode Not Updated	$6,607.63
Ineligible Providers	$1,382.23
Incorrect Billing	$234.00
25% Discount Override	$66.05
KPHA Providers Added With Incorrect Discounts	$47,529.39
Total Overpayments May 2003 Audit	$205,745.70

Further testing was implemented in the supplemental audit to specifically identify the amount of overpayments discovered as a result of the initial audit sample and to determine additional areas lacking controls to prevent overpayments in health care benefits. An additional $110,458.30 was discovered as a result of network providers being paid as referrals in the supplement audit. In addition, it was discovered that the initial audit included $35,781.04 that was identified incorrectly as overpayments. The net overpayment discovered in the initial and supplemental audit is reported as follows:

Overpayments May 2003 Audit	$205,745.70
Overpayments February 2004 Supplemental Audit	$110,458.30
Incorrectly Calculated Overpayments May 2003	($35,781.04)
Total County Overpayments	$280,422.96

IV. Audit Conclusions:

A1. Numerous Dimension provider claims were paid as referrals and resulted in an overpayment of $83,997.72 for the period January 1, 1999 to August 18, 2003 and is due the County. The providers have been notified and $7,058.19 has been received.

A2. Numerous KPHA provider claims were paid as referrals and resulted in an overpayment of $3,774.68 for the period January 1, 2000 to August 18, 2003 and is due the County.

A3. KPHA dental providers were added to Acordia's system incorrectly. Acordia calculated the claims resulting in an overpayment of $22,685.90. The dentists have been notified and $5,715.18 has been received.

B. Group Insurance Management stated that payment for surgical procedures should be calculated according to Medicare's Multiple Surgery Guidelines. These guidelines would provide the County additional savings in health benefits. Correspondence between the County and Acordia has not clarified the guidelines to be implemented.

C. Review of the Single Provider Payment Listing reports for the network hospitals identified claims that did not have the appropriate discounts applied. The hospital rescinded the discounts, if the claim was not paid in 30 days and Acordia refunded the discounts.

D1. The initial audit dated May 27, 2003 identified an overpayment of claims based on an outdated fee schedule. Acordia recalculated the claims and determined the overpayment to be $134,729.77. The physicians have been notified and $36,666.22 has been received.

D2. The initial audit included incorrect discounts for durable medical equipment in the amount of $10,424.01. It has been determined that KPHA Case Management negotiates the charges and the standard discount is not applied to these claims.

D3. The initial audit included a physician administering cancer drugs that are not subject to the comparison per an agreement between the County and KPHA. The provider was incorrectly reported by Acordia as having an overpayment of $25,357.03.

E. Numerous providers are billing with more than one federal tax identification number. The claims were paid as out of network claims. A provider can only be matched to a specific network if they bill their claims with the tax identification number provided to Acordia by the network. Numerous providers also have multiple suffixes added to their tax identification number. This can be a result of a change of address, data entry error, or multiple locations or as a result of being in a Group-Base as well as providing individual services and the provider may not be updated to the appropriate network.

F. Group Insurance Management should perform regular audits of Acordia claims and reports.

G. Group Insurance Management has changed health care benefits passing substantial cost to the employee. With proper information and education employees will have the ability to scrutinize claims and potentially assist in the reduction of health care cost.

A. Network Providers Paid Incorrectly

The auditors reviewed Referral Analysis reports, Single Provider Payment Listings and Acordia's schedule of overpayments from the May 27, 2003 audit and found additional claim processing errors. The breakdown of the claims in the supplemental audit are as follows:

Dimenision Providers	(938 Claims)	$83,997.72
KPHA Providers	(223 Claims)	$3,774.68
Dentists	(2,144 Claims)	$22,685.90
Total		$110,458.30

1. Dimension provider claims paid as referrals

Finding:

Numerous Dimension provider claims were paid as referrals, but the providers are actually participants in the Dimension Network. This was determined by review of the Referral Analysis Report. Providers paid as referrals were paid at the in network rate of 80% or 100%. A laboratory that joined the Dimension Network on January 1, 1999 had claims paid as referrals and the claims should have been paid based on the Dimension Fee Schedule. For example, one procedure code (82784) had a charge of $359.42 and Acordia paid $288.00. The Dimension Fee Schedule amount was $27.60. Therefore, Acordia should have only paid $22.08 (80% of $27.60). The overpayment for Monroe County's 80% portion on this one CPT code was $208.32. A claim should only be processed as a referral if it is not a network provider. Acordia's management produced computer reports to determine the extent of the overpayment.

For the period January 1, 1999 through August 18, 2003, five Dimension providers were overpaid a total of $83,997.72. Acordia is in the process of recouping the overpayments. Acordia has received payment from one Dimension provider in the amount of $7,058.19.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should monitor the collection process of the overpayment due the County.

County Administrator's Response:

1. Management believes claims should always be processed as network provider and if no network shows up, the system should check for referral before decision to assess penalty. The referrals are generally lab tests and the quantity of them should not be prohibitive for checking. The processing of lab tests on a referral basis was implemented because management believed it was unfair to the

participants to have them responsible for finding a network lab. Group Insurance Management is reviewing the Referral Analysis Report to prevent this from occurring again.

2. Group Insurance Management is aware that the collection process is taking a significant amount of time. Providers are very upset that we can go back for a longer period of time than they have been allowed to bill claims. They believe the process has been unfair to them. KPHA has received numerous complaints; and as of March 1, 2004, we have had eight providers opt out of the network.
3. As identified above by the auditors, Acordia is already in the process of recouping the overpayments. Management will be sure that this continues. In the future, management will establish a periodic review of claims by the County's insurance consultant for the purpose of identifying and resolving problems.

2. KPHA provider claims paid as referrals

Finding:

Numerous KPHA provider claims were paid as referrals, but the providers are actually participants in the KPHA Network. This was determined by review of the Referral Analysis Report. Providers paid as referrals were paid at the in network rate of 80% or 100%. A claim should only be processed as a referral if it is not a network provider. Acordia's management produced computer reports to determine the extent of the overpayment.

For the period January 1, 1999 through August 18, 2003, the KPHA providers were overpaid a total of $3,774.68.

Recommendation(s):

1. Group Insurance Management should establish a program of audits and inquiries on a periodic basis to ensure that the plan is functioning as intended.
2. Group Insurance Management should monitor the collection process of the overpayment due the County.

County Administrator's Response:

1. Management believes claims should always be processed as network provider and if no network shows up, the system should check for referral before decision to assess penalty. The referrals are generally lab tests and the quantity of them should not be prohibitive for checking. The processing of lab tests on a referral basis was implemented because management believed it was unfair to the participants to have them responsible for finding a network lab. Group Insurance Management is reviewing the Referral Analysis Report to prevent this from occurring again.
2. Group Insurance Management is aware that the collection process is taking a significant amount of time. Providers are very upset that we can go back for a longer period of time than they have been allowed to bill claims. They believe the process has been unfair to them. KPHA has received numerous complaints; and as of March 1, 2004, we have had eight providers opt out of the network.
3. This is a similar situation to the previous finding. Management will be sure that this continues. In the future, management will establish a periodic review of claims by the County's insurance consultant for the purpose of identifying and resolving problems

3. KPHA dental providers added to Acordia's system incorrectly

Finding:

Five dental providers in KPHA were added to Acordia's system incorrectly or not properly updated. Acordia provided the auditors a report correctly calculating the discounts and an overpayment of $22,685.90 was made to the providers. Acordia corrected the discounts and notified the providers of the overpayments and $5,715.18 has been received.

Incorrect payments would have continued indefinitely since the set-up did not contain accurate information. Acordia should furnish KPHA a provider listing with tax identification numbers and discount percentages allowed to review and correct on a periodic basis.

Recommendation(s):

1. Group Insurance Management should monitor the collection process of the overpayment due the County.
2. Group Insurance Management should establish guidelines to ensure Acordia's listing of network providers is accurate.

County Administrator's Response:

2. Group Insurance Management will continue the collection process.
3. Effective January 1, 2004, Monroe County has ceased being a self-insured provider of Dental Services. Employees are paying for their own insurance through American General.
4. Group Insurance Management will utilize the services of the insurance consultant for the purpose of monitoring Acordia's listing of all KPHA Network Providers to be sure that it is accurate.

B. Payment Method Employed for Surgical Procedures

Finding:

Group Insurance stated that payment for surgical procedures should be calculated according to Medicare's Multiple Surgery Guidelines and was under the assumption that Acordia was using this method. This assumption was based on a letter sent to Acordia from Group Insurance requesting Medicare guidelines be used for unbundling. See Exhibit A - Letter to Acordia, June 18, 2001.

Acordia states unbundling of charges and multiple surgeries guidelines are two different issues. See Exhibit B - E-mail from Acordia, August 26, 2003. Their system, Code Review, already bundles and unbundles procedure codes including surgeries. The multiple surgery guidelines are applied after the procedure codes have been bundled or unbundled. The following claim is an example of unbundling:

> CPT Code 43750 and 43246 were combined into one code 43246. There was also another procedure code 36533 for $1,200. Acordia stated, our Nurses have indicated that this procedure was not performed through the same incision as the primary procedure, therefore, we did not reduce to 50% of the Medicode Fee. However, based on Medicare's Multiple Surgery, which differs from ours, this would have been reduced to 50% regardless and should have been limited to 50% of $1,200 or $600.

The auditors requested Acordia to reprice all surgery claims from October 1, 2001 through June 30, 2003 and Acordia informed the auditors this was unrealistic and not feasible. See Exhibit B - E-mail from Acordia, August 26, 2003. The auditors were unable to determine the extent of overpayment resulting from the miscommunication between Acordia, KPHA and Group Insurance Management.

Acordia is able to amend the plan with written instructions based on the e-mail of August 26, 2003 from Acordia. See Exhibit B -E-mail from Acordia, August 26, 2003. There has been no correspondence between the County and Acordia clarifying the guidelines to be implemented.

Recommendation(s):

1. Group Insurance Management should discuss the consequences of using Medicare's Multiple Surgery Guidelines with KPHA.
2. Group Insurance Management should also consider including an acknowledgment form to be signed by Acordia Management that states the change has been made and the date it was implemented.

County Administrator's Response:

1. Group Insurance Management has discussed both Multiple Surgery Guidelines and Unbundling with KPHA. We are satisfied with the procedure being used by Acordia on unbundling. After much discussion and research, we have agreed to

the following Multiple Surgical Procedures that will be included in the next plan revision:

> Surgery includes the medically necessary preoperative and post operative care, when performed by a Physician. If two (2) or more operations or procedures are performed on the same day, on the same patient, by the same Physician, benefits are described in the Schedule of Benefits and subject to the usual, customary, and reasonable charges (or network fee schedule) for the first procedure, and 50% of usual, customary, and reasonable charges (or network fee schedule) for any additional procedures performed.

2. Group Insurance Management will develop an acknowledgment form to be signed by Acordia stating the appropriate changes have been made and the date of the implementation.

C. Discounts Rescinded by Providers

Finding:

The auditors reviewed Single Provider Payment Listing reports for the network hospitals and requested a sample of claims that did not have the appropriate discount applied. The review identified Fisherman's Hospital rescinding discounts on claims that were not paid within 30 days by Acordia. Acordia informed the auditors if additional information is requested the 30 days begins after receipt of all documentation necessary to analyze the claim and process appropriately. Acordia paid the original billed charges less the provider discount and if the claim was paid past the 30 day period the hospital would request the discount be paid. See Exhibit C - Sample Letter from Fisherman's Hospital. The sample of 6 claims revealed a total of $33,716.48 paid to Fisherman's Hospital based on discounts rescinded.

The KPHA contract provides the following definition for provider compensation:

> **Participating Provider Compensation:** All claims for covered services, whether payable by the Employer or a Covered Person will receive a discount off of provider billed charges as specified in Attachment A. This discount will be rescinded if an appropriately documented and non-contested claim is not paid to the Participating Provider within thirty (30) days of being received by the claims administrator (Acordia National).

Group Insurance Management is working with KPHA to revise the contract language to define clean claims and disputed claims. See Exhibit D - Email from KPHA.

Recommendation(s):

1. Group Insurance Management should ensure that Acordia calculates prompt pay discounts according to the terms of the KPHA Proposal and Agreement.
2. Group Insurance Management should review Refund and Reversal reports provided by Acordia to monitor provider discounts that have been refunded.

County Administrator's Response:

1. The language in the KPHA contract was confusing as to what constituted a 'non-contested claim'. In the new contract with KPHA, effective March 1, 2004, we have defined a "Clean Claim, " Notification of Claim Status" and " Disputed Claims". This should prevent the discrepancy caused with the handling of discounts such as those documented with Fisherman Hospital.
2. Group Insurance agrees with the recommendation to monitor the Refund and Reversal Report.
3. Group Insurance Management will officially inform KPHA that the practice identified for Fisherman's Hospital is not within the scope of the Contract between the County and KPHA. KPHA will be asked to inform Fisherman's Hospital that practice must be discontinued.

D. Overpayments Identified in May 2003 Health Benefit Program Audit

1. KPHA provider claims paid as referrals

Finding:

The initial audit dated May 27, 2003 identified physician claims for the KPHA network using an outdated Medicode Fee Schedule for the usual and customary comparison, which resulted in multiple claims being overpaid. The County requested the claims be reprocessed on August 5, 2003. See Exhibit E - Letter to Acordia, August 5, 2003. The total County adjustments calculated by Acordia resulted in an overpayment amount of $134,729.77. The providers have been notified and repayment of $36,666.22 has been received. As of February 12, 2004, the outstanding balance is $98,063.55.

Recommendation(s):

1. Group Insurance Management should monitor the collection process of the overpayment due the County.
2. Group Insurance Management needs to ensure procedures are in place to verify the Medicode Fee Schedule is updated annually.

County Administrator's Response:

1. Group Insurance Management is aware that the collection process is taking a significant amount of time. Providers are very upset that we can go back for a longer period of time (15 months) than they have been allowed to bill claims. They believe the process has been unfair to them. KPHA has received numerous complaints; and as of March 1, 2004, eight providers have left the network. As of March 31, 2004 we have increased the repayment amount of $36,666.22 to $70,379.81.
2. We were the only client of Acordia that was using Medicode. It created a very cumbersome system for processing and updating. Effective March 1, 2004, our contract with KPHA has started using P.H.C.S. (formerly HIAA) Fee Schedule. All other Acordia Clients use P.H.C.S. This should make the processing and updating easier and more efficient. Acordia will update their system and it will be effective for all their providers. KPHA providers have agreed to this new system in their contract with KPHA
3. Group Insurance Management will semi-annually confirm that the P.H.C.S. Fee Schedule is being utilized appropriately.

2. Incorrect discounts for durable medical equipment

Finding:

The initial audit dated May 27, 2003 identified claims with incorrect discounts totalling $47,529.39. Included in the amount was $10,424.01 for durable medical equipment claims that did not have the standard KPHA discount of 15%. During the supplemental audit it was discovered the rates for medical equipment are negotiated by KPHA Case Management. The standard discount of 15% does not apply to durable medical equipment claims, but a case management fee is billed to the County. Subsequently, the auditors determined the overpayment identified as "incorrect discounts for durable medical equipment" should not have been included as an overpayment in the initial audit.

Group Insurance Management and KPHA agree the discount should not be applied to durable medical equipment. However, the contract does not indicate durable medical equipment is processed differently from other KPHA claims.

Recommendation(s):

1. Group Insurance Management should document and include all processing conditions in the contract.

County Administrator's Response:

1. Group Insurance Management will document the processing for Durable Medical Equipment in the next plan document. As much as Group Insurance Management would like to be able to document all processing in our plan document, we continue to find unique medical situations that have to handled administratively based on what serves the patient as well as what keeps the cost as low as possible for the plan.

3. 90th Percentile Medicode overpayment

Finding:

The initial audit dated May 27, 2003 identified claims being processed with the 1997 90th Percentile Medicode. Acordia ran preliminary reports identifying $52,877.70 as the overpayment due to the outdated Medicode. Included in the amount was $25,357.03 which was for one physician administrating prescription drugs. It had been determined by the County and KPHA that the service the physician provided would not be subject to the medicode comparison. However, the physician had discrepancies in his billing procedures and gave the appearance of an overpayment in the initial audit. For example, one claim was billed for 40 units at $30.09 with a total charge of $904.00 and a total of $858.80 was paid. The payment was correct even after being compared to the 90th Percentile of Medicode. The next claim billed 1 unit at $30.09 with a total charge of $904.00 and a total of $858.80 was paid, but the spreadsheet calculation gave the appearance of the claim being overpaid $830.21. The preliminary overpayment calculated by Acordia was prepared in a formula based spreadsheet and did not take into account examiner overrides. The physician will not be billed the calculated overpayment of $25,357.03 by Acordia.

Recommendation(s):

1. Group Insurance Management should review all documentation provided by Acordia to ensure calculations and procedures are accurate.

County Administrator's Response:

1. Group Insurance Management along with KPHA and Acordia are monitoring processing to maintain the accuracy of the system. Medicode will no longer be our basis; as of March 1, 2004, we will be using P.H.C.S. (formerly HIAA).